Suicide: What We Need to Know

Satellite Conference and Live Webcast
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Produced by the Alabama Department of Public Health
Video Communications and Distance Learning Division

Faculty

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Learning Objectives

- Identify common triggers of suicide
- Identify stressors
- Identify symptoms of compassion fatigue
- Identify warning signs of suicide
- Take appropriate action in response to an at-risk individual

Suicide Statistics

- Suicide is the 10th leading cause of death for Americans of all ages
- Suicide is the 2nd leading cause of death for Americans ages 15-24
- Everyday over 100 Americans take their own life

Centers for Disease Control

Suicide Statistics

- There are over 1 Million suicide attempts annually which translates to 1 attempt every 31 seconds
- Men are three times more likely to complete a suicide than females. Females are three times more likely to attempt a suicide than males

Centers for Disease Control

National Suicide Statistics

- Region, Year: United States, 2012
- Population: 313,873,685
- Reported Suicides: 40,600
- Unreported suicides: 5% - 25% more
- Suicide Behaviors: 40-100 times greater than number of suicides

National Suicide Statistics

- Number of People affected: each instance of suicide or suicide behavior can affect a few or a large number of people
- People with thoughts of suicide: 15,693,684

Living works education

Alabama Suicide Facts:

- In 2013 the AL Suicide Rate was 14.9 (per 100,000) which was higher than the National Suicide Rate of 13.0 (per 100,000)
- In 2013 the AL Suicide Rate (14.9) was double the homicide rate (7.1)
- In 2013 there were 420 deaths due to homicide, while there were 719 deaths due to suicide
- In 2013 there were 84 youth suicides (ages 10-24) in Alabama

National Study of Police Suicides (NSOPS)

- This was a review of almost 50,000 emails, the monitoring of news and websites and the voluntary contributions from many in the field
- The fact is that police suicides continue at a rate much higher than the number of police officers killed by felons

National Study of Police Suicides (NSOPS)

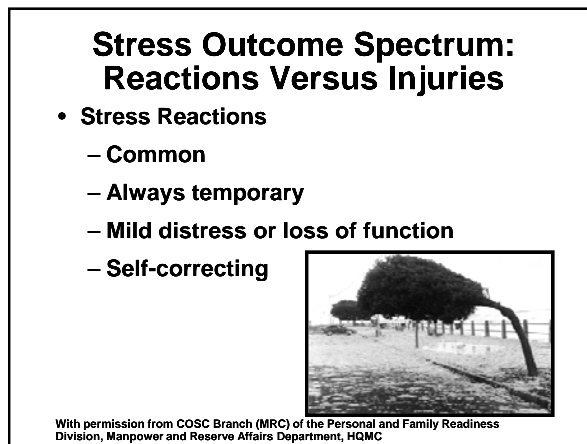
– This alone reminds us of the need to redouble our efforts, not only at suicide intervention, but on the maintenance of mental health in law enforcement

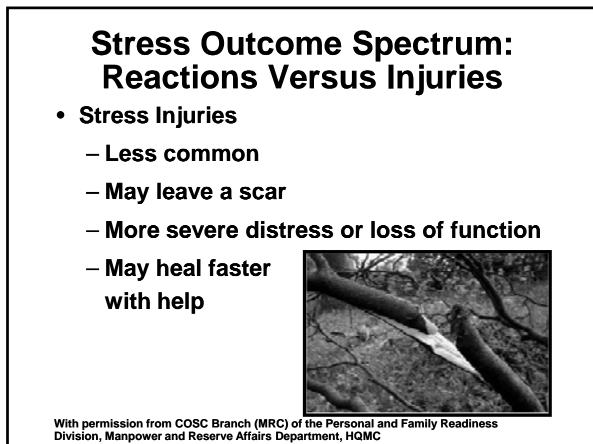
National Study of Police Suicides (NSOPS)

- We cannot lose sight of the fact that the officer whose mind is on other problems, be they at home or at work, is a danger to himself and other officers who are relying on him
  – Much remains to be done

Law Enforcement Numbers

- Studies show there are 125 to 150 police suicides per year, at a rate of 14 - 17/100,000 (the public is 11/100,000 and the Army in 2010 was 20/100,000) this number is 3 times the number of officers *killed by felons*





Sources of Stress

PHYSICAL	• Heat • Dehydration • Injury or illness • Cold • Sleep deprivation • Toxins
THINKING	• Being hyper-focused • Boredom • Uncertainty • Lack of information • Too much information
EMOTIONAL	• Fear of injury or death • Fear of failure • Hatred • Horror • Guilt or shame • Anxiety or depression
SOCIAL	• Being away from loved ones and friends • Loss of personal space • Isolation • Family • Gambling • Financial • Divorce • Work Issues
SPIRITUAL	• Life doesn't make sense like it used to • Challenge of faith • Moral conflict

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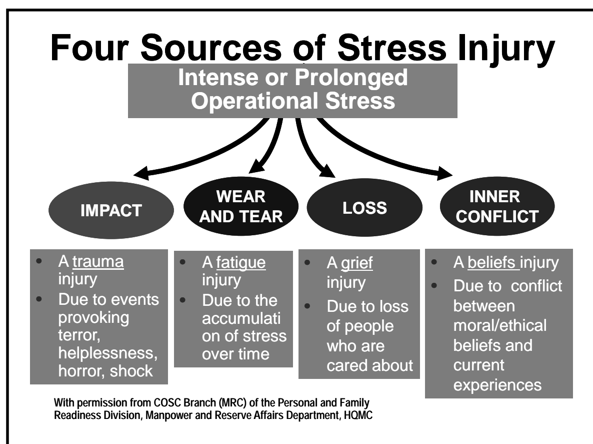

How Do You Check for Stress?

Sources of Information and Key Indicators of Stress

Key Indicators	Sources of Information: Observation	Sources of Information: Listening
Current Stressors	Watch for operational stressors during deployment or training	Ask about personal or home-front stressors
Level of Distress	Watch for uncharacteristic and intense anger, anxiety, sadness or fear	Ask about troubling thoughts or emotions, especially guilt or shame
Effectiveness of Functioning	Watch for changes in job performance, self-care, or getting along with peers	Ask about physical symptoms, sleep problems, and self control

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Stress Can Lead to Isolation:

- Humiliation / Ridicule / Rejection
- Failed Relationship
- Drug or Alcohol Abuse
- Avoid friends or family
- Exposure to trauma
- Family stressors
- Family history of problems, suicide, mental health issues, finances

Isolation……leads to despair..

- Everyone thinks…
- I never get included…
- I am not good enough…
- I am not cool enough…
- I do not look good enough…
- Everyone else does…
- No one cares…
- No one will miss me

Despair Can Lead to Hopelessness:

- Believing no one can help and all resources have been exhausted
- Feeling that no one cares or understands
- Believing the world (or your family and friends) would be better off without you

Despair Can Lead to Hopelessness:

- Seeing death as only means of eliminating pain
  (It is an explosion of pain)

Hopelessness Can Lead to… Death

- Suicide is the 10th leading cause of death for Americans of all ages
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Hopelessness Can Lead to… Death

- There are over 1 Million suicide attempts annually which translates to 1 attempt every 31 seconds
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Centers for Disease Control

Hopelessness

- Believing all resources have been exhausted
- Feeling that no one cares
- Believing the world would be better off without you
- Total loss of control over self and others
- Seeing death as only means of eliminating pain
- Financial Rewards for Family

Perspective???

- Commitment (vs. alienation)
  - Ability to feel deeply involved in activities of life
- Control (vs. powerlessness)
  - Belief you can control or influence events of your experience
- Challenge (vs. threat)
  - Anticipation of change as an exciting challenge to further development

Beliefs??? Values???

- Beliefs are ideas held to be true
- Belief in a non-physical dimension of life
- Provide support in times of stress
- Spiritual values, and the core issues of meaning and purpose in life are also beliefs
- These May have changed as a result of Trauma Exposure

Triggers for Suicidal Behavior

- Recent interpersonal losses
- Loss of self-esteem / status
- Humiliation / Ridicule
- Rejection (e.g., job, promotion, boy/girlfriend)
- Disciplinary or legal difficulty

Triggers for Suicidal Behavior

- Exposure to suicide of friend or family member
- Discharge from treatment or from service
- Retirement

SUICIDE Myths and Facts

- MYTH: People who talk about suicide don't die by suicide.
- FACT: 80% of completed suicides had given definite indications of their intention.
- MYTH: Talking about suicide will give some an idea to do it.
- FACT: Suicidal people already have the idea. Talking about it may invite them to ask for help.

SUICIDE Myths and Facts

- MYTH: All suicidal people are fully intent on dying. Nothing can be done about it.
- FACT: 95% are undecided about it. They call for help before or after the attempt.
- MYTH: Suicide is an impulsive act.
- FACT: Most suicides are carefully planned and thought about for weeks.

SUICIDE Myths and Facts

- MYTH: Suicidal people remain suicidal.
- FACT: Most are suicidal for only a brief period. Timely intervention may save their lives.
- MYTH: Suicidal persons are mentally ill.
- FACT: Most suicidal persons are not mentally ill. Severe emotionally distress is not the same as mental illness.

SUICIDE Myths and Facts

- MYTH: December has the highest suicide rate.
- FACT: December has one of the lowest rates. Spring months have the highest.
- MYTH: It's not suicide if there is no note.
- FACT: Only 1 in 4 suicides leave suicide notes.

Responding to Statements or Threats

- Stay calm. Do not leave person alone.
- ACE: Ask, Care, Escort
- Ask the Question: "Are you thinking of killing yourself?"
- Care: "Buy time" (i.e., Identify stressor and reasons for living).
- Escort: Ensure the person receives help

Compassion Fatigue…

- Figley (1993, 1995) defined compassion fatigue ''as the natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other, the stress resulting from helping or wanting to help a traumatized or suffering person

Compassion Fatigue…

- Figley later coined the term compassion fatigue to describe the cognitive emotional behavioral changes that caregivers experience from indirect exposure to trauma survivors or suffering person'' (p.7)

Compassion Fatigue

- Gentry, Baranowsky and Dunning, (2002) reported that the likelihood of experiencing compassion fatigue is higher for those working with the traumatized
- Compassion Fatigue (CF) generates potential behaviors that can be disruptive in both the professional and personal life of those who are dealing with it

Compassion Fatigue Symptoms

- Compassion Fatigue (CF) generates potential behaviors that can be disruptive in both the professional and personal life of those who are dealing with it
- Intrusive secondary trauma-related thoughts or memories
- Avoidance behaviors

Compassion Fatigue Symptoms

- Sleep disturbances
- Irritability
- Dissociation

Compassion Fatigue Symptoms

- Anxiety, disconnection, avoidance of social contact, difficulty maintaining the therapeutic alliance, depression, somatization and disrupted beliefs about the self and others. (Beder, Joan C. (2012), Sprang et al. (2007)

Compassion Fatigue Symptoms

- Gradual onset of negative feelings (defensive response, psychological strain) that may be associated with: feeling that your efforts make no difference, lack of control and input, insufficient rewards, a very high workload, inadequate support, a non-supportive work environment (work demands perceived as difficult to address or amend) (Stamm, 2005, Canfield, 2005).

Compassion Fatigue Symptoms

- Emotional exhaustion, depersonalization, reduced sense of accomplishment (Maslach, Jackson & Leiter, 1996), physical exhaustion, dissatisfaction about oneself, cynicism towards others (Ballanger-Browning, et al., 2011)

Compassion Fatigue Symptoms

- Reduced sense of trust, safety, power, esteem, intimacy, independence and control
- These attributes when combined can generate feelings of burnout and ambiguous loss
- Burnout: Work-related hopelessness and feelings of inefficacy

Secondary Trauma

- John Violanti, (2012) , probably the most reliable researcher on police suicides, in 2012 concluded that approximately 15 - 18 percent of working police officers in the US are having undiagnosed symptoms of PTSD

Secondary Trauma

- He stated "In a diagnosis of PTSD, there must be a traumatic event (or multiple traumatic events such as cops see) in the person's life, without an identified traumatic event, no PTSD”

Secondary Trauma

- However, many who work in law enforcement are exposed to secondary traumatic stress as a result of what their colleagues have experienced

Social Barriers

- We’re socialized to be smart, strong, triumph over adversity
- Paradox, compromise, uncertainty and adaptation are less positively identified (devalued)
- Gaining resilience to deal with ambiguous loss requires understanding the process and our own feelings in the context of grief. Boss, Pauline (2010, 2006)

Migitaers

- Some studies suggest that personal coping styles and the ability to construct meaning in the face of stressful experiences may be a truer determinant of Professionals’ emotional functioning (Follette, Polusny & Milbeck, 1994; Ortlepp & Friedman, 2001)

Migitaers

- Autonomy and control seem to be mitigating factors for burnout (Abu-Bader, 2000; Vredenburgh et al., 1999),

Mitigaters

- Supportive work environments and adequate supervision were noted to mitigate the incidence of STS and burnout (Boscarino et al., 2004; Korkeila et al., 2003; Ortlepp & Friedman, 2002; Webster & Hackett, 1999)

Mitigaters

- Access to sufficient resources mitigated both burnout and STS (Abu-Bader, 2000; Ortlepp & Friedman, 2001). P.262

Resilience and Hardiness

- Resilience: The ability to grow and thrive in the face of challenges and bounce back from adversity.
- Hardiness: (Commitment, Control, Challenge) is the specific way an individual improves resilience.
- Resilience is an outcome of Hardiness

Personal Resiliency Plan

- Identify strengths and areas that need improvement
- Develop specific goals that improve strengths and address areas that need improvement on both a personal and leadership level

Personal Resiliency Plan

- Response: Objectives:
  - Identify the problem
  - Encourage help-seeking behaviors
  - Become proficient in “Buddy Care”

Resources

- Badger, K.; Royse, D.; Craig, C., (2008) Hospital social workers and indirect trauma exposure: An exploratory study of contributing factors; Health & Social Work Vol. 33, p63-71, 9p. Document Type: article; (AN HSW.CC.FC.BADGER.HSWITE)
- Beder, Joan C. (2012). Social work in the Department of Defense Hospital: Impact of the work.Advances in Social Work. 13(1), 132-148.
- Boss, Pauline (2010). The trauma and complicated grief of ambiguous loss. Pastoral Psychology, 59, 137-145.
- Boss, Pauline (2006). Loss, trauma and resilience: Therapeutic work with ambiguous loss. W.W. Norton & Co. Inc., NY,NY.

Resources

- Degeneffe, C.E., Chan, F., Dunlap, L., Man, D., & Sung, C. (2011). Development and validation of the Caregiver Empowerment Scale: A resource for working with family caregivers of persons with traumatic brain injuries. Rehabilitation Psychology. 56(3), 243-250.
- Sprang, G., Clark, J. & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. Journal of Loss and Trauma. 12, 259-280.
- http://www.badgeoflife.com/resources.php

www.woundedblue.com

Support Our Military Families

- AlaVetNet
- Not Alone
- Courage Beyond
- Military OneSource
- Army OnceSource
- VA Choice Providers (Check VA website on how to join)
- Alabama Joining Community Forces on Facebook